

Use of High-Value Preventive Care and Lives Saved If Use Improved

This chapter documents the use of preventive care among the general U.S. population for 12 of the 25 clinical preventive services included in the National Commission on Prevention Priorities' rankings of preventive services. These 12 services are the only ones among the 25 that have utilization data available.^{9,10} Data on use of these services among racial and ethnic groups are presented in the following chapter of this report. All 12 services fall into the top-half of the NCPP's rankings.

This chapter also quantifies the health impact, in most cases the lives saved, if utilization among all people eligible for the service were increased from current levels to 90 percent.

Discuss Daily Aspirin Use

The U.S. Preventive Services Task Force (USPSTF) recommends that health care providers discuss the benefits and potential harms of regular use of low-dose aspirin with men age 40 and older, postmenopausal women, and younger people with risk factors for coronary heart disease (such as smoking, diabetes, and hypertension). Aspirin is a preventive treatment for heart disease, including heart attacks and the most significant disease consequence of heart attacks, congestive heart failure.

Current surveillance systems are not tracking the extent to which providers are advising adult patients to consider using aspirin daily to lower their risk of heart disease. The data presented here are on the number of at-risk adults who report using aspirin daily.

Among men age 40 and older and women age 50 and older, 40.2 percent were taking aspirin daily or every other day for any reason in 2005. The trend is moving very slowly in the right direction, but annual changes in the data must be interpreted cautiously (see footnote to the chart).

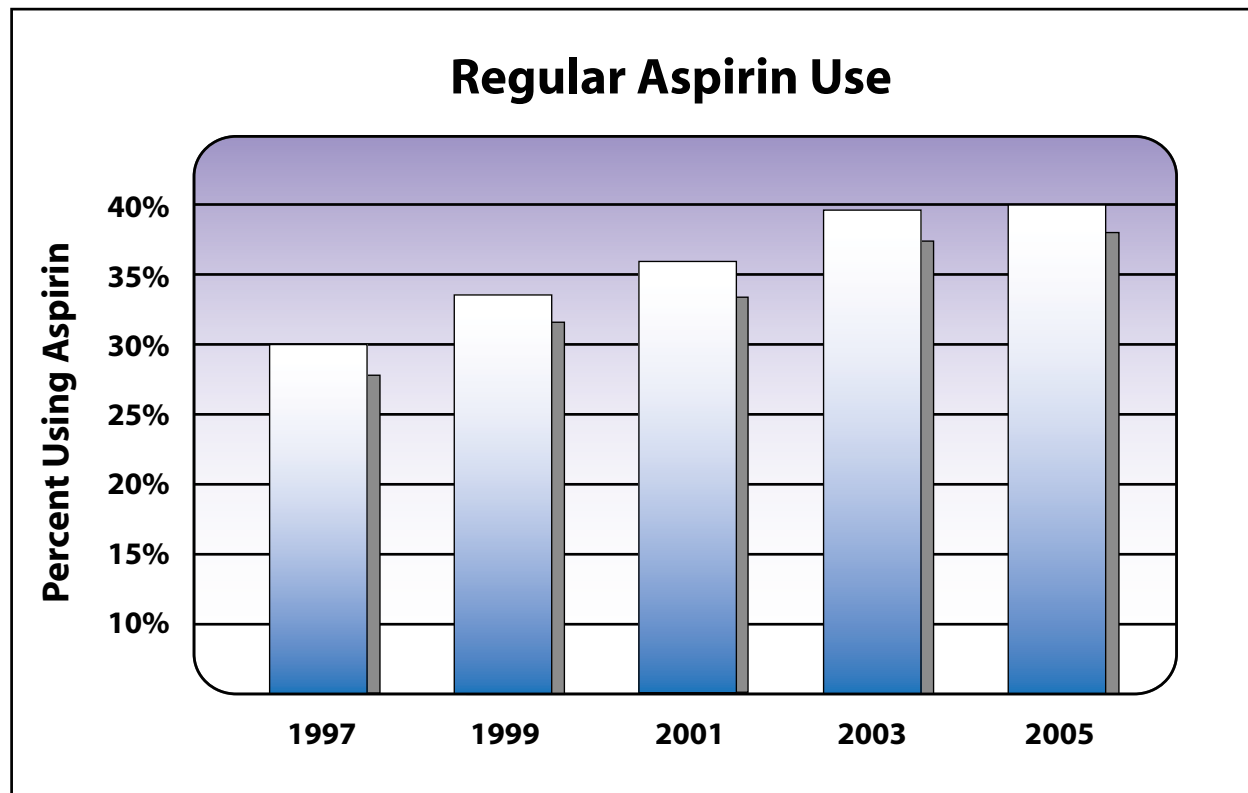
Although aspirin is cheap and accessible, fewer than half of adults report using it consistently over extended periods. More adults need guidance from their doctors to start and maintain an aspirin regimen.¹¹ Counseling at-risk adults to consider using aspirin daily would save about \$70 per

⁹ For 11 of these 12 services, data are available from well-regarded national telephone surveys. Utilization data for chlamydia screening comes from private health plans that report HEDIS® data to the National Committee for Quality Assurance. Thus, the chlamydia screening rate reported here provides only a limited approximation of the extent to which all eligible women are being screened. Data on utilization by racial and ethnic group are not available for chlamydia screening.

¹⁰ The appendix to this report provides a summary of the gaps in the data on utilization of all 25 preventive services.

¹¹ A nationally representative online survey assessing aspirin use among 1,300 adults aged 40+ found that having a discussion with one's provider was the factor most strongly associated with aspirin use. One-third of all respondents reported discussing aspirin use with a provider. Among those reporting a discussion, 88 percent reported regular aspirin use; 17 percent who took aspirin regularly did not report a discussion with a health care provider. Source: Pignone M et al. Aspirin use among adults aged 40 and older in the United States: results of a national survey. *Am J Prev Med* 2007; 32(5):403-407.

person counseled, assuming that about 50 percent of people comply with physician advice.¹² The cost-savings of 90 percent compliance with physician advice to use aspirin would be greater.¹³



Source: Behavioral Risk Factor Surveillance Survey, CDC

Notes: (1) Percent refers to men age 40 and older and women age 50 and older who report aspirin use every day or every other day for any reason.

(2) The aspirin question is a state-optional (non-core) question. The states that chose to include this question vary from year to year and therefore annual changes in use of aspirin should be interpreted cautiously.

HEALTH IMPACT			
ASPIRIN USE IN MEN 40+ AND WOMEN 50+			
Population Group	% Currently Reporting Daily Aspirin Use (2005)	Lives Saved Annually if Daily Use of Aspirin Increased to 90%	Lives Saved Annually Per 100,000 if Daily Use Increased to 90%
Men 40+ Women 50+	40%	45,000	23

¹² HealthPartners Research Foundation and Partnership for Prevention. Aspirin for the Primary Prevention of Cardiovascular Disease: Technical Report Prepared for the National Commission on Prevention Priorities. June 2006.

¹³ Aspirin use is not necessarily the correct choice for all people with increased risk for coronary heart disease. The USPSTF recommends that clinicians discuss the risks and benefits of aspirin, rather than encourage all eligible patients to use aspirin. For comparison to other preventive measures, we use 90% utilization to estimate the potential health benefits. Approximately 10% of individuals have aspirin sensitivity and many of these can be helped with desensitization therapy (Gollapudi RR, Teirstein PS, Stevenson DD, Simon RA. Aspirin sensitivity: implications for patients with coronary artery disease. JAMA. 2004 Dec 22;292(24):3017-23).

Childhood Immunizations

Although there remains significant room for improvement, utilization rates for most childhood vaccines are high, and disparities in utilization rates between racial and ethnic groups have been largely eliminated among children under age three. According to the Centers for Disease Control and Prevention, in 2005 the pneumococcal conjugate vaccine, which was first recommended in 2000, reached greater than 50 percent utilization for the full four-dose series for the first time.¹⁴

Vaccination Rates Among Children 19-35 Months of Age			
Vaccine/Dosage	2001	2003	2005
DTP/DT/DTaP			
≥3 doses	94.3	96.0	96.1
≥4 doses	82.1	84.8	85.7
Poliovirus	89.4	91.6	91.7
<i>Haemophilus influenzae</i> type b			
≥3 doses	93.0	93.9	93.9
Measles, mumps and rubella			
≥1 dose	91.4	93.0	91.5
Hepatitis B			
≥3 doses	88.9	92.4	92.9
Varicella			
≥1 dose	76.3	84.8	87.9
Pneumococcal conjugate			
≥3 doses	n/a	68.1	82.8
≥4 doses	n/a	35.8	53.7
Combined series			
4:3:1:3:3:1*	61.3	72.5	76.1
* ≥4 doses of diphtheria, tetanus toxoids and pertussis vaccines; diphtheria and tetanus toxoids vaccine; or diphtheria, tetanus toxoids vaccine and any acellular pertussis vaccine (DTP/DT/DTaP); ≥3 doses of poliovirus vaccine; ≥1 dose of MMR vaccine; ≥3 doses of <i>Haemophilus influenzae</i> type b vaccine; ≥3 doses of hepatitis B vaccine; and ≥1 dose of varicella vaccine.			
Source: National Immunization Survey, United States, 2001-2005			

¹⁴ Centers for Disease Control and Prevention. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months - United States, 2005. MMWR 2006; 55(36):988-993.

Higher vaccination rates for children compared to adults did not happen overnight: it was the result of a concerted effort by doctors, parents, government agencies, health insurers, employers, and advocacy groups to bring about the change. Time, attention, good record-keeping, insurance coverage, safety net programs, and public policies all help ensure that many children in the United States get vaccinated. Continued vigilance is essential to ensure that successes do not erode. Similar approaches will be necessary to increase the use of other preventive services. Based on rates of disease in the pre-vaccination era, approximately 15 million cases of disease and 35,000 deaths are currently prevented annually by childhood immunizations.¹⁵

Smoking Cessation Advice and Help to Quit

The USPSTF recommends that health care providers screen all adult patients for tobacco use and provide brief, behavioral counseling (less than three minutes) including 1) urging patients in a clear and strong message that quitting is important to their health and 2) offering medications to aid in quitting and/or referrals to community programs or for more intensive counseling. Twenty percent of adults smoke,¹⁶ and one-third of smokers will die prematurely as a result.¹⁷ Smoking cessation is beneficial at any age and it eliminates the risk of harming others with secondhand smoke.

Counseling adult patients who smoke to quit saves about \$500 per smoker counseled.¹⁸ Tobacco cessation advice and help to quit saves more money than it costs because so much is saved in downstream medical costs that it completely offsets the upfront costs of identifying and treating smokers—and that includes the medical costs of those who quit and those who do not.¹⁹

¹⁵ HealthPartners Research Foundation and Partnership for Prevention. Childhood Immunizations: Health Impact and Cost Effectiveness. Technical Report Prepared for the National Commission on Prevention Priorities, 2006.

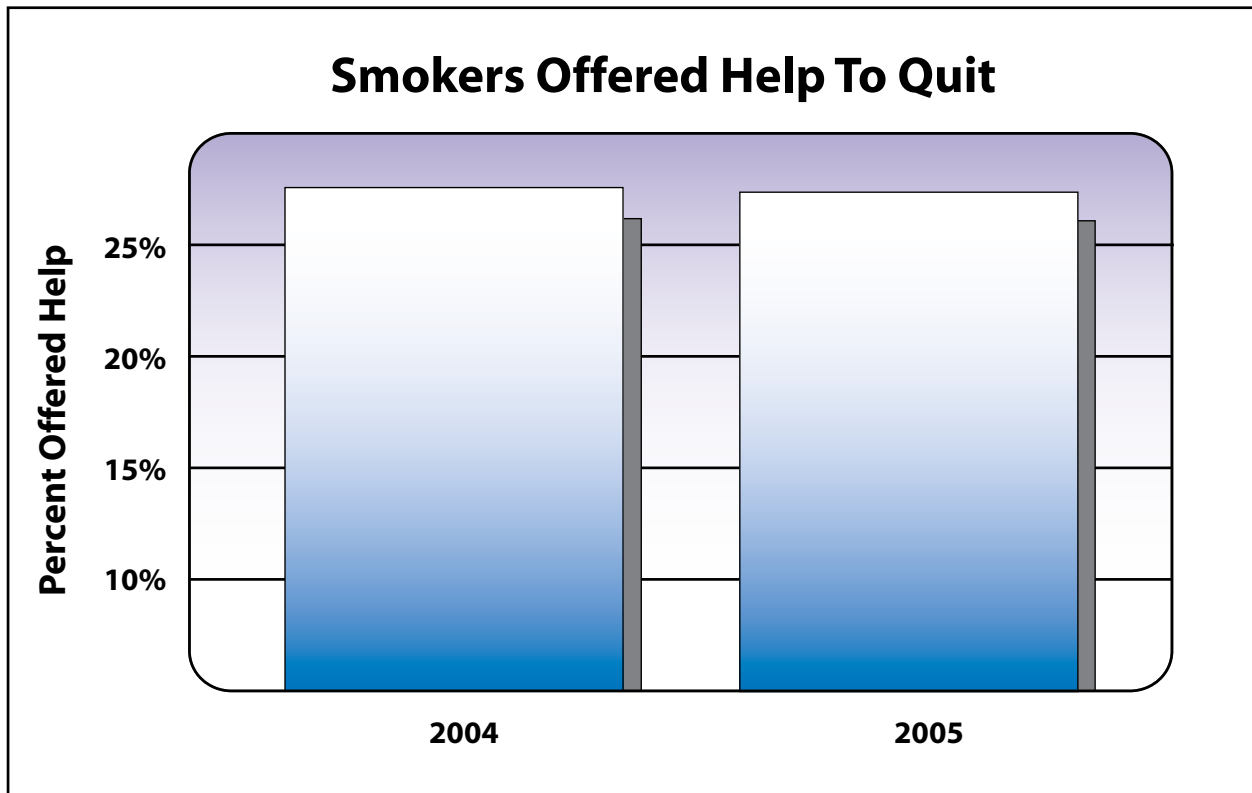
¹⁶ Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2004. [Web Page]; <http://www.cdc.gov/brfss/>. [Accessed 24 Mar 2006].

¹⁷ Projected smoking-related deaths among youth – United States. *Morb Mortal Wkly Rep* 1996 Nov 8;45(44):971-4.

¹⁸ Solberg LI, Maciosek MV, Edwards NM, Khanchandani HS, Goodman MJ. Repeated tobacco use screening and intervention in clinical practice: health impact and cost effectiveness. *Am J Prev Med* 2006; 31(1):62-71.

¹⁹ Existing literature indicate that the average 12-month quit rate in clinical practice for smoking cessation counseling with cessation medications is about 5%. The effectiveness of repeated counseling over the lifetime of smokers may be as high as 20% (Source: See Solberg LI, et al. above.)

In 2005, 27.5 percent of smokers reported that, in the past 12 months, a doctor, nurse or other health professional offered them medication assistance to quit smoking or strategies other than medication to assist with quitting.²⁰ This compares to 27.6 percent in 2004 (see footnotes to the charts on the limitations of the trends). A higher percentage of smokers, 47.9 percent, reported receiving advice to quit smoking by a health professional in the past 12 months. Advice to quit smoking does not fulfill all of the recommended counseling actions; to be effective, smoking cessation counseling must also include offers of assistance. There remains great potential for saving lives and dollars by offering professional advice and assistance to a much greater percentage of smokers annually.



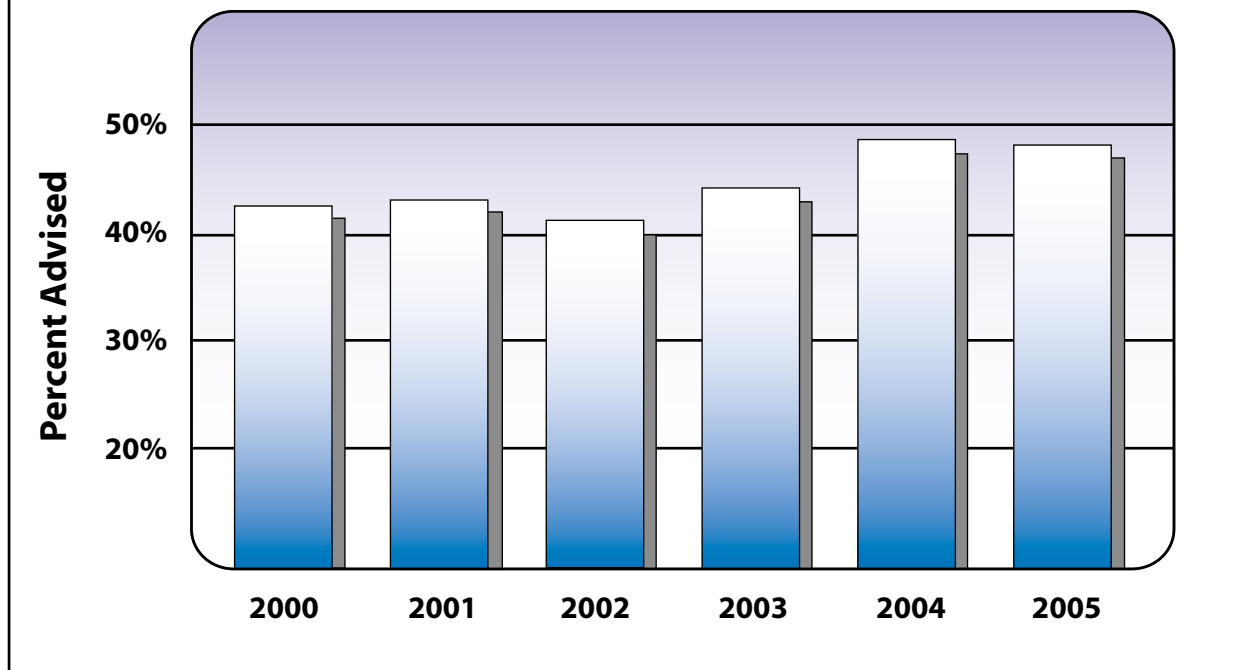
Source: Behavioral Risk Factor Surveillance Survey, CDC

Notes: (1) Percent of smokers 18+ years of age who had a doctor, nurse or other health professional discuss medication assistance to quit smoking OR recommend/discuss methods or other strategies other than medication to assist with quitting smoking in the past 12 months.

(2) This question is a state-optional question. The states that chose to include this question varied from year-to-year and therefore annual changes in the percentage of smokers offered help to quit should be interpreted very cautiously.

²⁰ These data are consistent with HEDIS® performance data. An analysis of 2005 HEDIS® data showed that 26.8% of smokers 18 years and older reported receiving advice to quit smoking, discussion of smoking cessation medication, and discussion of smoking cessation strategies from a health professional in the past year. These are smokers enrolled in commercial health plans that report HEDIS® data to the National Committee for Quality Assurance.

Smokers Advised To Quit In Past 12 Months



Source: Behavioral Risk Factor Surveillance Survey, CDC

Notes: (1) Percentage of adult smokers age 18 and older who were advised by a doctor or other health provider to quit smoking in the past 12 months

(2) This question is a state-optional question. The states that chose to include this question varied from year-to-year and therefore annual changes in the percentage of smokers advised to quit should be interpreted very cautiously.

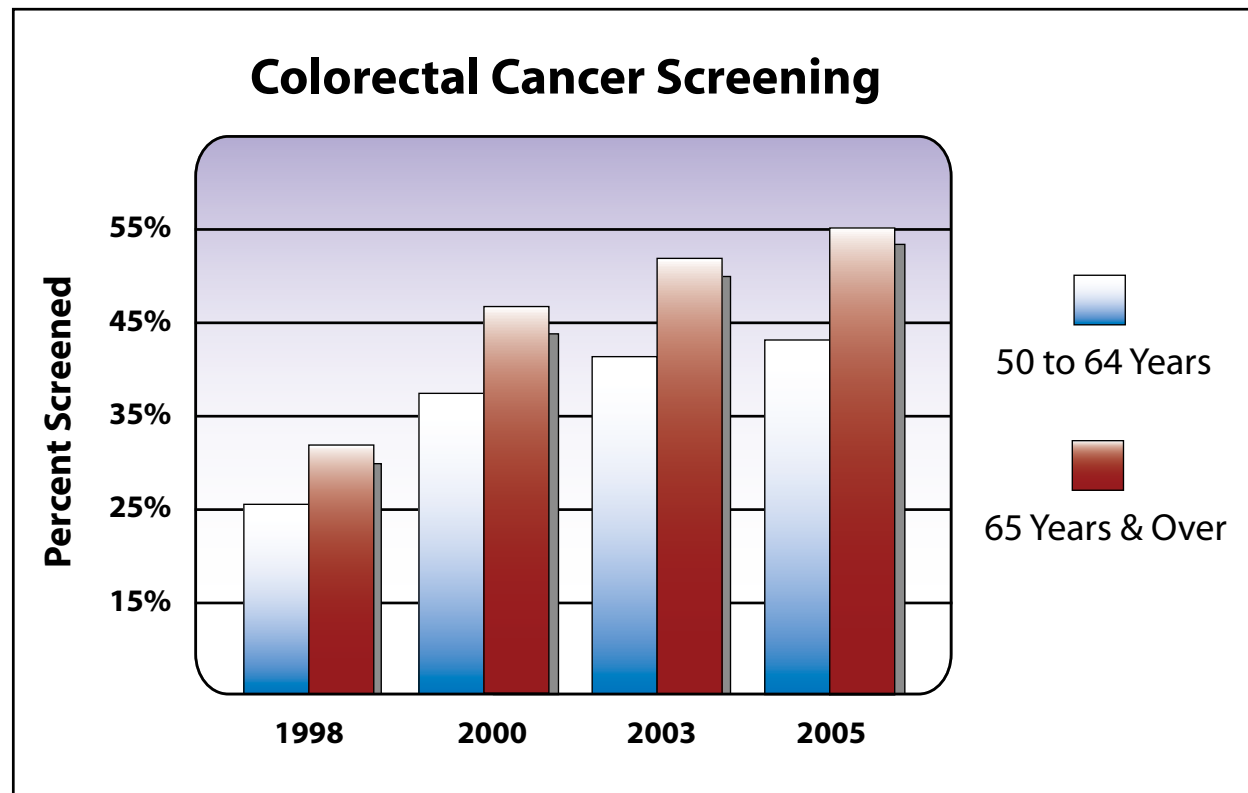
(3) Starting in 2001, receipt of advice to quit smoking was only asked of smokers who reported seeing a health professional in the past 12 months. We assigned a “no” response (did not receive advice to quit in past 12 months) to all smokers who did not report seeing a health professional in the past 12 months. This makes the rates presented here comparable with other services in this report. For example, the rate of women who have had a mammogram in the past two years is among all women, not just those women who have seen a health professional in the past 2 years. Among smokers who had seen a health professional in the past 12 months, 69.6 percent, 69.5 percent, 71.1 percent, 64.1 percent and 62.1 percent reported receiving advice to quit in 2001-2005. The 2004 and 2005 surveys included more detailed questions regarding receipt of information on medication or other assistance to quit smoking (see previous chart).

HEALTH IMPACT			
SMOKING CESSATION ADVICE AND HELP TO QUIT			
Population Group	% of Smokers Who Were Offered Help to Quit in Past 12 Months (2005)	Lives Saved Annually If % of Smokers Offered Help to Quit Increased to 90%*	Lives Saved Annually Per 100,000 Smokers If % Offered Help to Quit Increased to 90%
All Adult Smokers	28%	42,000	43
*Lives saved based on smokers given earnest advice to quit and offered medication assistance, other strategies, and referral to community-based programs or for more intensive counseling.			

Colorectal Cancer Screening

The USPSTF recommends screening all men and women age 50 and older for colorectal cancer. Screening options include home fecal occult blood testing (FOBT), flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema. Clinicians are advised to talk to patients about the benefits and potential harms associated with each option before selecting a screening strategy. Fifty-seven thousand people die annually from colorectal cancer. If all people were screened periodically with recommended methods, 33,000 colorectal cancer deaths could be prevented each year.

The number of adults age 50 and older who were up to date on colorectal cancer screening (any recommended method) increased from 28.9 percent in 1998 to 48.1 percent in 2005. The rate of improvement has been steady but slow. The screening rate increased from 42.0 percent in 2000 to 46.3 percent in 2003. Adults over age 65 have higher screening rates compared to adults ages 50-64 years: 43.5 percent of adults ages 50-64 were up to date on screening in 2005 compared to 54.8 percent of adults age 65 and older.



Source: National Health Interview Survey, National Center for Health Statistics, CDC

Notes: Portion of adults age 50 and older who have had a colonoscopy in the past 10 years, sigmoidoscopy in the past five years, proctoscopy within the past five years, or home blood stool test in past two years, all for screening purposes only.

²¹ Maciosek MV, Solberg LI, Coffield AB, Edwards NM, Goodman MJ. Colorectal cancer screening: health impact and cost effectiveness. *Am J Prev Med* 2006; 31(1):80-89.

²² Data from the Behavioral Risk Factor Surveillance Survey (2006) indicate that 57% of adults nationwide report ever having had a sigmoidoscopy or colonoscopy. This rate is higher because it is not limited to tests that were received within 5 years for sigmoidoscopy or 10 years for colonoscopy. Also this rate does not exclude tests that were for diagnostic purposes.

HEALTH IMPACT			
COLORECTAL CANCER SCREENING IN ADULTS 50+			
Population Group	% Up to Date with Screening (2005)*	Lives Saved Annually If % Up to Date with Screening Increased to 90%	Lives Saved Per 100,000 If % Up to Date with Screening Increased to 90%
Adults 50+	48%	14,000	18
*Screening up to date with any recommended method			

Hypertension Screening

The USPSTF recommends measuring the blood pressure of all adults age 18 and older and treating adults for high blood pressure with anti-hypertensive medication. High blood pressure is prevalent in the U.S. and can lead to heart attack or stroke: thirty percent of Americans age 20 and older have hypertension; nearly 50 percent develop hypertension before age 65.²³ Weight gain is associated with an increased risk of developing hypertension.

The most recent data on hypertension screening from the National Health Interview Survey are from 2003. Rates of hypertension screening within the past two years were very high among all adults age 18 and older in 2003 (86.5 percent), ranging from 82.5 percent for adults ages 18-34 to 92.3 percent for adults 65 and older. The chart shows that in 2003 more women 18 and older reported screening in the past two years (90.1 percent) compared to men (82.8 percent), a difference that has not changed since 1998 when the rate was 90.1 percent for women and 81.9 percent for men.

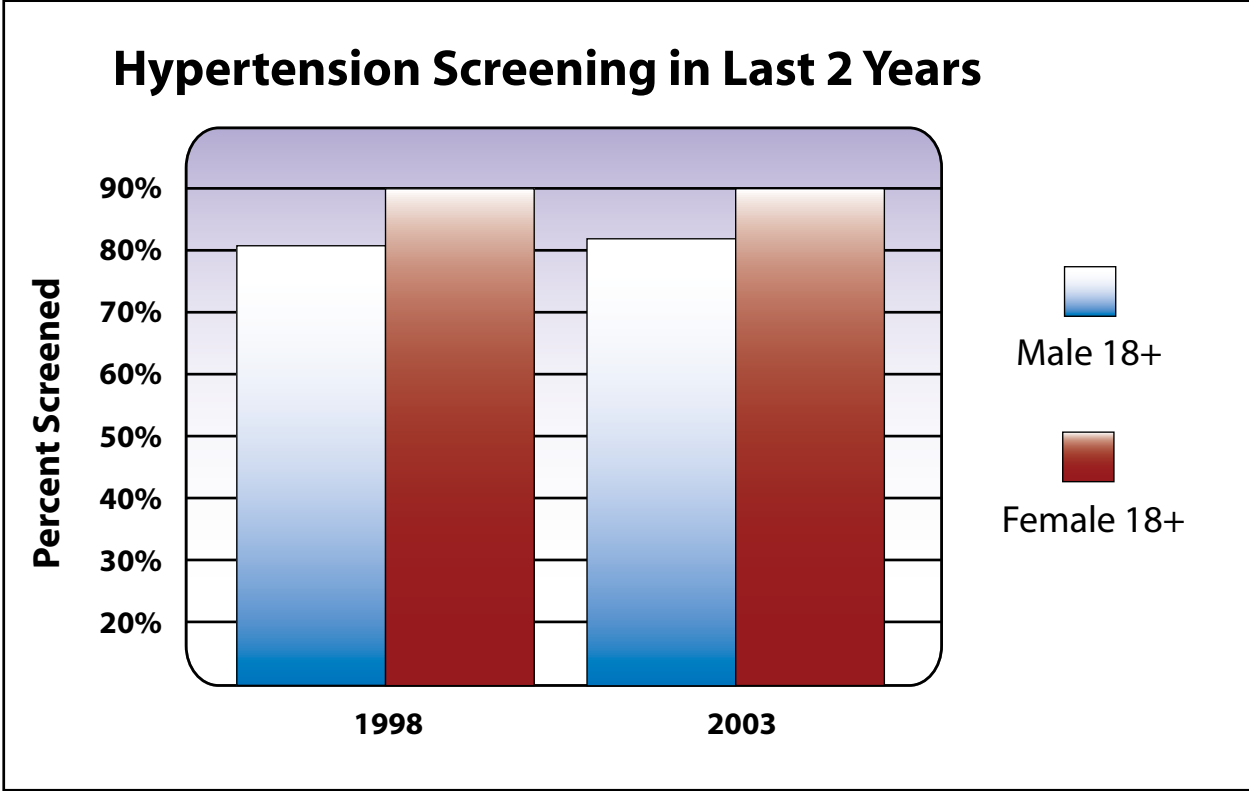
The additional health impact of attaining screening rates of 90 percent is approximately zero because screening rates have reached this level among the age groups at greatest risk for developing cardiovascular disease. The maximum benefit of screening is gained through consistent, long-term use of anti-hypertensive medications. Among people who have been screened, long-term persistence with medication is about 40 percent.^{24, 25, 26} Rather than concentrating resources on increasing screening rates, resources would be better used to ensure that people who have been screened and are hypertensive are aware of their condition and continue taking their medication regularly.

²³ National Center for Health Statistics. Health, United States, 2005 With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland: 2005.

²⁴ Caro JJ, Salas M, Speckman JL, Raggio G, Jackson JD. Persistence with treatment for hypertension in actual practice. CMAJ 1999 Jan 12;160(1):31-7.

²⁵ Conlin PR, Gerth WC, Fox J, Roehm JB, Boccuzzi SJ. Four-Year persistence patterns among patients initiating therapy with the angiotensin II receptor antagonist losartan versus other antihypertensive drug classes. Clin Ther 2001 Dec;23(12):1999-2010.

²⁶ Ansell BJ. Improvement in current approaches to lipid lowering. Am Fam Physician 2002 Mar 1; 65(5):783, 786-7.



Source: National Health Interview Survey, National Center for Health Statistics, CDC

Influenza Immunization - Adults

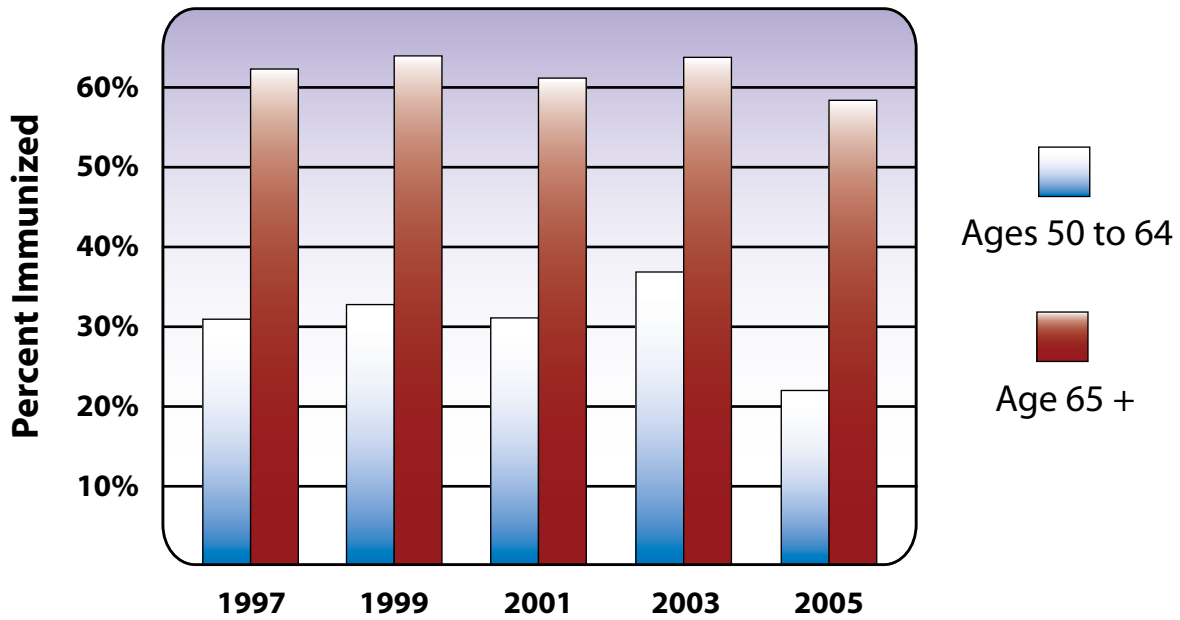
The Advisory Committee on Immunization Practices (ACIP) recommends that all adults age 50 and older receive one dose of the influenza vaccine annually. ACIP also recommends vaccination in younger adults with certain risk factors or occupations (e.g., health care workers).

About 5 percent to 20 percent of Americans get influenza each year. Most people are better in less than two weeks, but some people develop dangerous complications, such as pneumonia. An average of about 36,000 people die from influenza annually, and more than 200,000 have to be admitted to the hospital as a result of influenza.²⁷ The single best way for adults to protect themselves is to get a flu shot each fall.

In 2005, only 37.3 percent of adults age 50 and older had been vaccinated against influenza within the previous 12 months: 22.6 percent of adults 50-64 and 58.3 percent of adults age 65 and older. The recommendations for adults age 50-64 to get an annual flu shot is relatively new, which may explain the lower rate in that age group. The vaccination rate for adults 50 and older in 2005 (37.3 percent) was 10 percentage points lower than in 1999 (47.5 percent). Supply challenges during the 2005 influenza vaccination season led to lower vaccine use in adults age 50 and older that year.

²⁷ Centers for Disease Control and Prevention. Influenza: The Disease. <http://www.cdc.gov/flu/about/disease.htm>

Influenza Immunization, Adults 50+



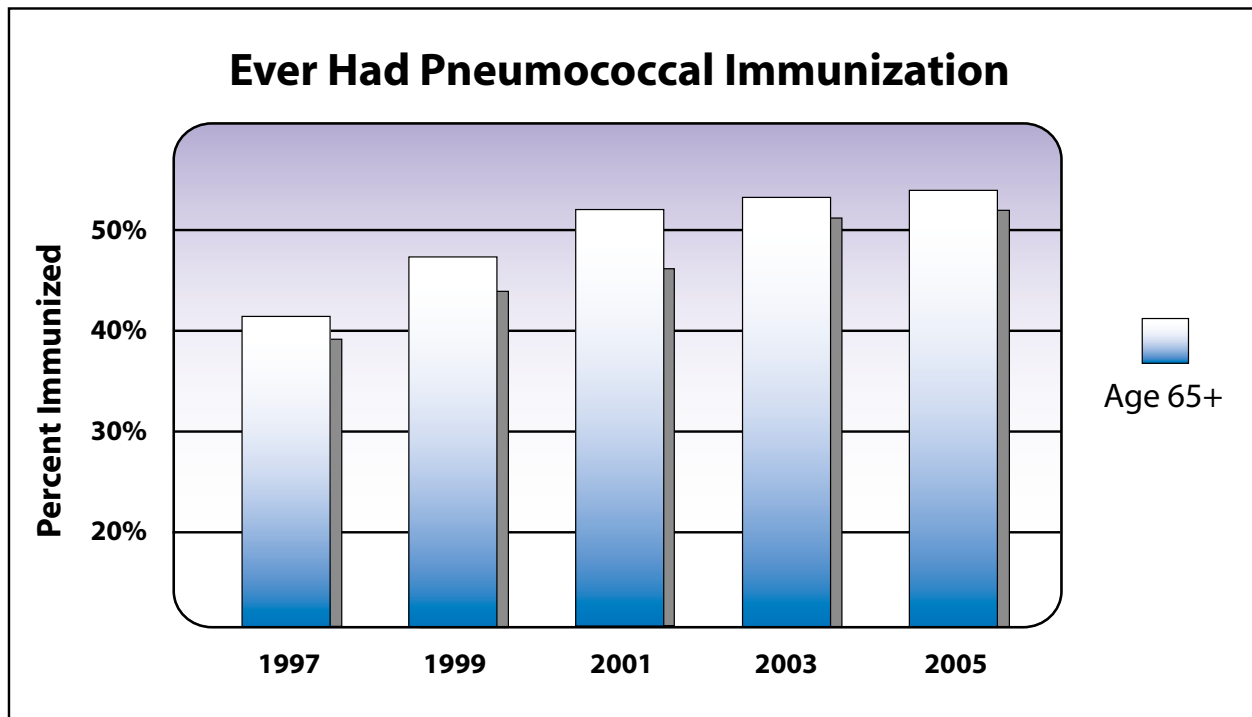
Source: National Health Interview Survey, National Center for Health Statistics, CDC

HEALTH IMPACT INFLUENZA VACCINATION, ADULTS 50+ YEARS			
Population Group	% Vaccinated Against Influenza in Past 12 Months (2005)	Lives Saved Annually if % Vaccinated Increased to 90%	Lives Saved Annually Per 100,000 If % Vaccinated Increased to 90%
Adults 50+	37%	12,000	14

Pneumococcal Immunization - Adults

ACIP recommends that all adults age 65 and older receive a dose of the pneumococcal polysaccharide vaccination. This highly cost-effective vaccine prevents hospitalization and death caused by a bacterial form of pneumonia. Emerging drug-resistant strains underscore the importance of prevention through vaccination.

In 2005, 54.1 percent of adults age 65 and older reported ever having had a pneumococcal immunization. The immunization rate has only increased by six percentage points since 1999 when the rate was 47.9 percent (the rate was 52.1 percent in 2001 and 53.5 percent in 2003). The pneumococcal and influenza vaccines are both covered with no cost-sharing for Medicare beneficiaries.



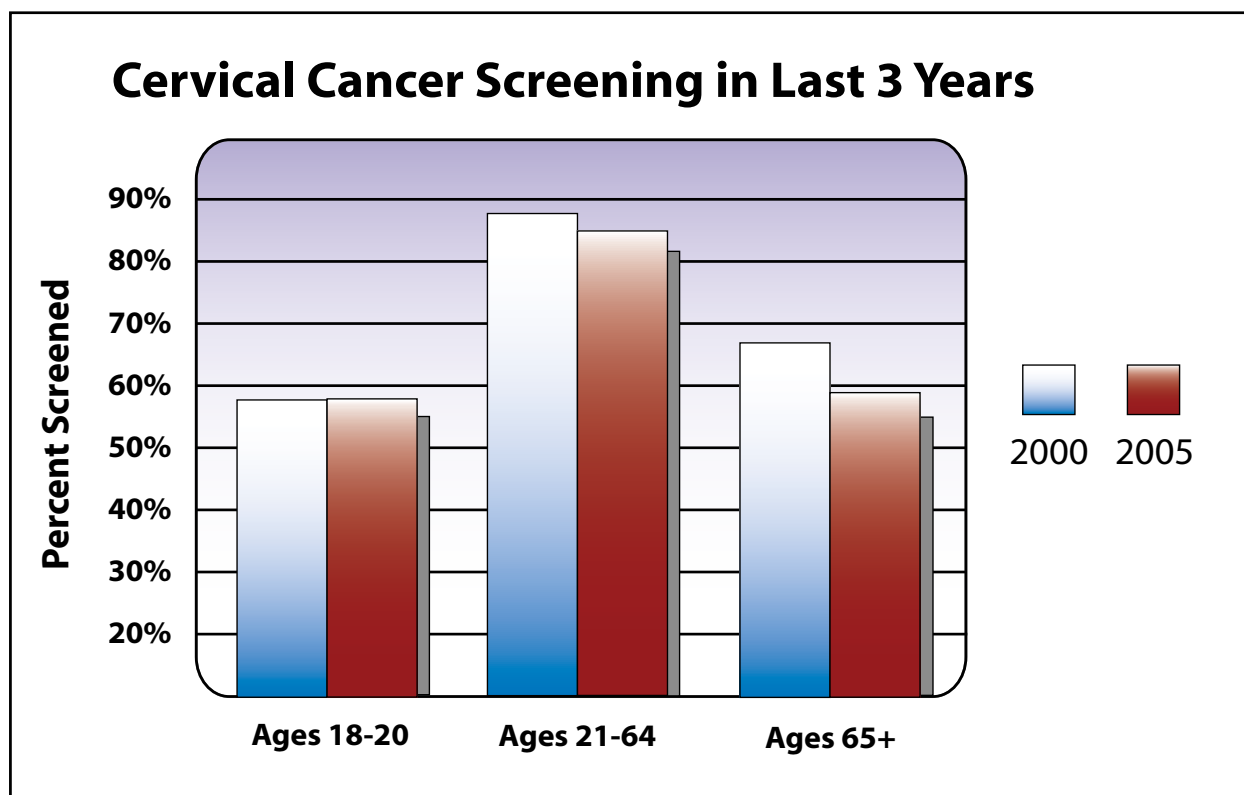
Source: National Health Interview Survey, National Center for Health Statistics, CDC

HEALTH IMPACT			
PNEUMOCOCCAL VACCINATION, ADULTS 65+ YEARS			
Population Group	% Ever Vaccinated Against Pneumococcal (2005)	Lives Saved Annually If % Ever Vaccinated Increased to 90%	Lives Saved Annually Per 100,000 If % Ever Vaccinated Increased to 90%
Adults 65+	54%	800	2

Cervical Cancer Screening

The USPSTF recommends screening with Pap smears to prevent the incidence of and mortality from cervical cancer. Most of the benefit is obtained by beginning screening within three years of the onset of sexual activity or age 21 (whichever comes first) and screening at least every three years thereafter. Women over age 65 can forego screening if they have had normal Pap smears with their most recent screenings and are not otherwise at high risk for cervical cancer. Cervical cancer is almost entirely preventable through screening. Regular screening with Pap smears is the major reason for the 30-year decline in cervical cancer mortality. Since 1998, the death rate from cervical cancer has remained near 3 deaths per 100,000 women.

In 2005, 80.3 percent of women age 18 and older reported having been screened for cervical cancer within the last three years, including 57.4 percent of women ages 18 to 20, 85.2 percent of women ages 21 to 64, and 59.4 percent of women age 65 and older. The rates were slightly higher five years earlier: In 2000, 82.6 percent of women reported having been screened, including 57.4 percent of women ages 18 to 20, 87.2 percent of women ages 21 to 64, and 67.6 percent of women age 65 and older. The biggest decline in screening was among women age 65 and older from 67.6 percent in 2000 down to 59.4 percent in 2005. In women age 65 and older, screening may not be necessary if they have had previous normal Pap smears. The data do not allow us to distinguish women who should be screened from those who should not. This trend may or may not reflect an appropriate decline in use of screening among women age 65 and older.



Source: National Health Interview Survey, National Center for Health Statistics, CDC

²⁸ U.S. Department of Health and Human Services. Healthy People 2010: *Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

HEALTH IMPACT CERVICAL CANCER SCREENING			
Population Group (2005)	% Screened in Past 3 Years	Lives Saved Annually If % Screened in Past 3 Years Increased to 90%	Lives Saved Annually Per 100,000 If % Screened in Past 3 Years Increased to 90%
Women 18-64	83%	620	0.8
Additional deaths would be prevented if screening in the past three years reached 90 percent among women age 65 and older who need continued screening. We did not estimate this because we do not know the portion of women age 65 and older who need continued screening nor what their current rate of screening is.			

Cholesterol Screening

The USPSTF recommends screening men 35 and older and women 45 and older for high cholesterol (except in cases where the patient has other risk factors, such as hypertension or diabetes, in which case screening should start sooner) and using lipid-lowering drug treatment in those with abnormal levels of cholesterol. Drug therapy is usually more effective than diet alone, but choice of treatment should be determined by overall risk, costs of treatment, and the patient's preferences.

As with hypertension, high cholesterol is prevalent in the United States: 21 percent of adults age 35 and older have high cholesterol, and of these, most develop high cholesterol before age 55.²⁹ Obesity, which has dramatically increased in the United States in recent decades, raises blood cholesterol levels. One out of four adults who do not control their high cholesterol will have a cholesterol-attributable heart attack. One out of three will die of cholesterol-attributable coronary heart disease.³⁰

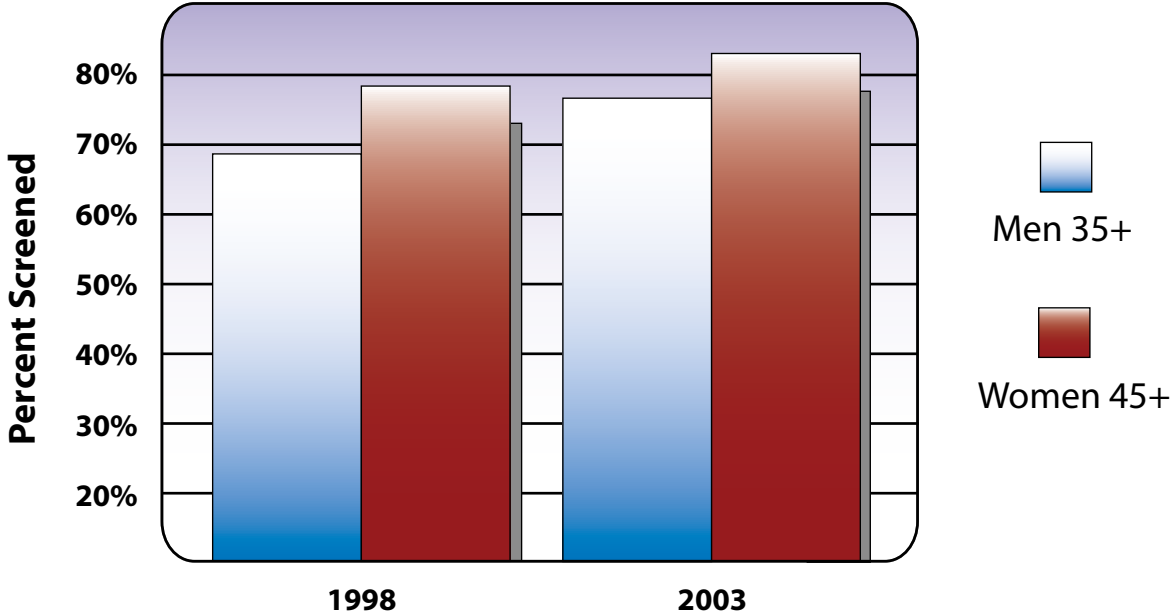
Among men age 35 and older and women age 45 and older, 79.4 percent reported screening in the past five years in 2003, which is the most recent year data are available. This is higher than the rate reported by the same group in 1998: 73.6 percent. Women reported screening at a higher rate than men in both 1998 and 2003: 69.7 percent and 76.4 percent of men reported screening compared to 78.8 percent and 83.1 percent of women.

The data indicate that one in five U.S. adults at-risk have not been screened for high cholesterol within the last five years. Although there remains room for improvement, screening rates are relatively high for this service. The maximum benefit of cholesterol screening is achieved through the long-term use of drug therapy. Among people who have been screened, long-term persistence with medication is about 40 percent.^{15,16,17} Rather than concentrating resources on increasing screening rates, resources would be better used to ensure that people who have been screened and have high cholesterol are aware of it and continue to take their medication regularly.

²⁹ National Center for Health Statistics. *Health, United States, 2005 With Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2005.

³⁰ Maciosek, MV, Edwards N M, Nelson WW, et al. Screening for high cholesterol. Technical report prepared for the National Commission on Prevention Priorities. 2006.

Cholesterol Screening in Past 5 Years



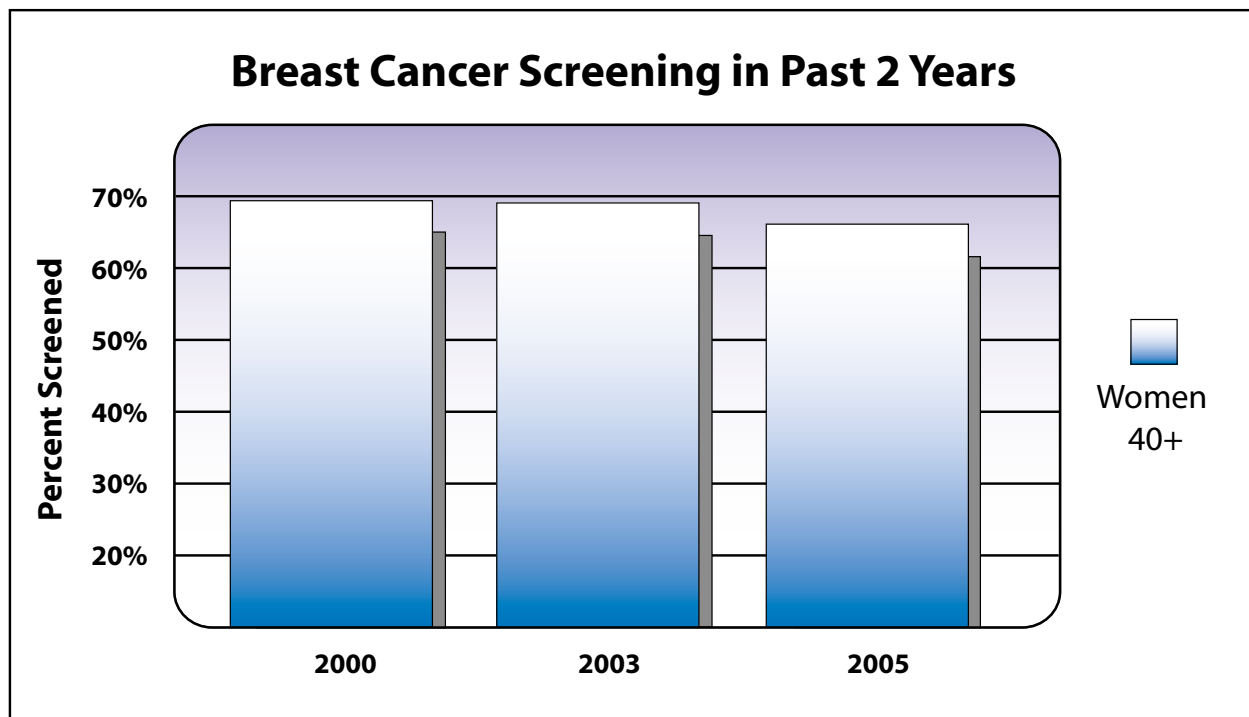
Source: National Health Interview Survey, National Center for Health Statistics, CDC

HEALTH IMPACT CHOLESTEROL SCREENING			
Population Group	% Screened in Past 5 Years (2003)	Lives Saved Annually If % Screened in Past 5 Years Increased to 90%	Lives Saved Annually per 100,000 If % Screened in Past 5 Years Increased to 90%
Men 35+, Women 45+	79%	2,450	5

Breast Cancer Screening

The USPSTF recommends screening mammography every one to two years for women age 40 and older to prevent breast cancer mortality. At current screening rates, mammograms prevent 12,000 deaths from breast cancer annually.³¹

In 2005, 67.0 percent of women ages 40 and older reported having had mammography screening within the previous two years. The trend is not positive: the screening rate in 2005 was lower than in 2000 when 69.2 percent of women reported screening within the previous two years. Mammograms help catch breast cancer early, when tumors are small and easier to treat successfully. If fewer women are screened on-time, more women will be diagnosed with advanced disease that is harder to control, and that could lead to higher breast cancer death rates.



Source: National Health Interview Survey, National Center for Health Statistics, CDC

HEALTH IMPACT BREAST CANCER SCREENING			
Population Group	% Screened with Mammography in Past 2 Years (2005)	Lives Saved Annually If % Screened in Past 2 Years Increased to 90%	Lives Saved Annually per 100,000 If % Screened Increased to 90%
Women 40+	67%	3,700	10

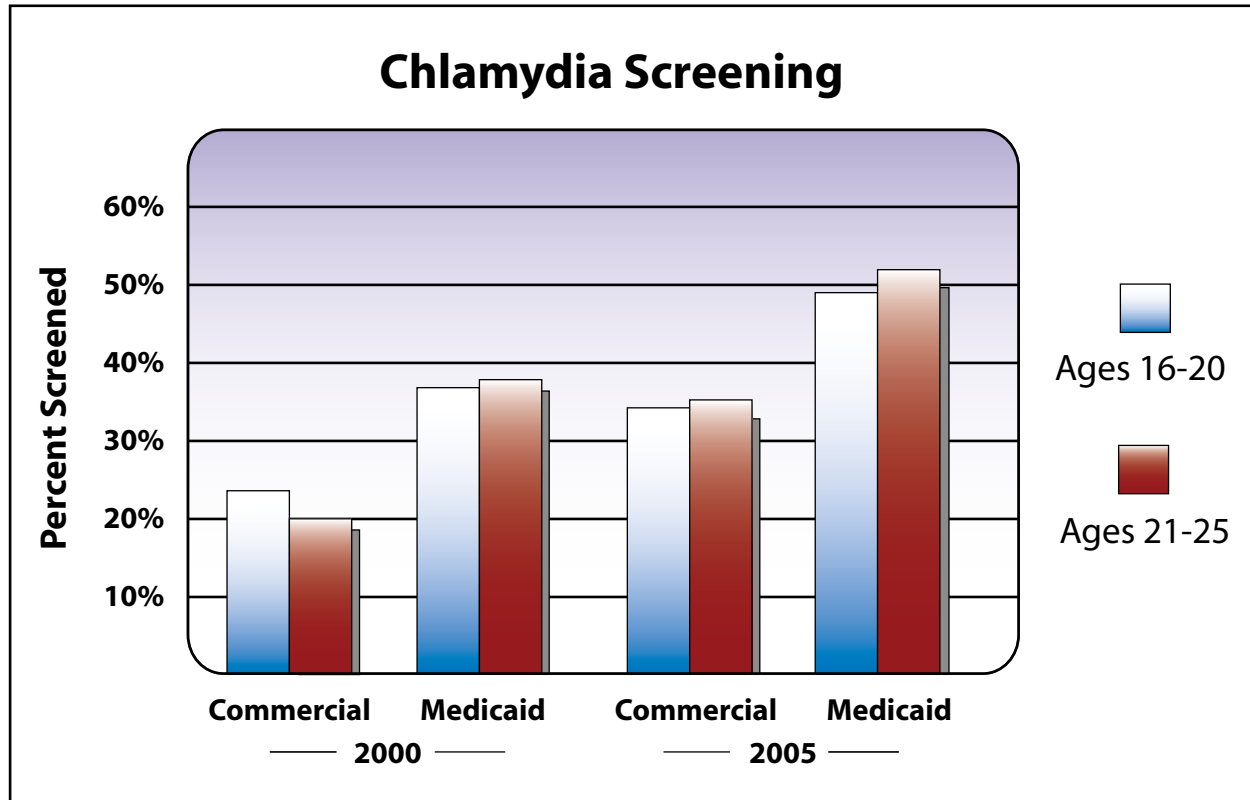
³¹ HealthPartners Research Foundation and Partnership for Prevention. Breast Cancer Screening: Health Impact and Cost Effectiveness. Technical Report Prepared for the National Commission on Prevention Priorities. May 2006.

Chlamydia Screening

The USPSTF recommends routine screening for chlamydial infection in sexually active women under age 25 and older women at increased risk. Chlamydia is the most common bacterial sexually transmitted disease in the United States, with 3 million new cases annually. Left untreated, chlamydia causes pelvic inflammatory disease and infertility in some women. Screening is especially important because most women have no symptoms.

Screening rates for sexually active women ages 16-25 are available from more than 500 commercial and Medicaid HMOs and point of service plans that report HEDIS® performance data. About 33 percent of Americans with health insurance are currently enrolled in these types of plans, not all of which report HEDIS® data. One could expect screening rates among the general population of young women to be lower than the HEDIS® rates reported here since measuring and publicly reporting data are likely to motivate health plans to improve utilization. On the other hand, these data may underestimate screening if young women are more likely to seek reproductive health care services from other types of providers, such as Title X-funded clinics.

HEDIS® data for 2005 show that screening rates among young women in commercial plans were significantly lower than rates for women in Medicaid plans: screening among young women ages 16-20 enrolled in commercial plans was 34.4 percent compared to 49.1 percent in Medicaid plans and screening among young women ages 21-25 was 35.2 percent compared to 52.4 percent in Medicaid plans.



Source: National Committee for Quality Assurance, State of Healthcare Quality 2006

Note: Percent screened include sexually active female plan members ages 16-25 who had at least one test for chlamydia during the measurement year.

HEALTH IMPACT CHLAMYDIA SCREENING			
Population Group	% Screened in 2005*	Cases of PID Prevented Annually If % Screened Increased to 90%	Cases of PID Prevented Annually Per 100,000 If % Screened Increased to 90%
Women 16-25	40%	30,000	13
*Approximate rate based on HEDIS® performance data.			



Vision Screening Among Children

The USPSTF recommends screening to detect amblyopia, strabismus and defects in visual acuity in children younger than age five. About 3 percent of preschoolers have visual impairments, a portion of which would remain undetected at school age without screening. Screening and treatment are inexpensive and can improve quality of life. The most recent data available for vision screening in preschool-age children from the National Health Interview Survey are from 2002. Thirty-six percent of parents reported that their child’s vision had been screened by a health professional. If screening were increased from 36 percent up to 90 percent, an additional 27,000 cases would be detected and may benefit from early treatment.